PMO 526
Health Services Organization
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Current Sectors of Health Care Delivery

A. Why is cost important?

1. Expenditures are exceeding revenue and the system cannot sustain itself.

2. The amount of money the system costs is so great that it could cause financial and medical resource problems.

3. An economically sound healthcare system promotes a healthy society

4. Cost drives innovation and change.

As with nearly every component of society, healthcare was also greatly changed by World War II. In the late 1930's the country was still in the "Great Depression." Those fortunate enough to afford medical care paid out of pocket to physicians with limited therapeutic resources at their disposal. The terminally ill were sent to hospitals that were funded by philanthropists and typically died from infectious diseases in what is now called mid-life. Great events and changes lay just ahead.

With the War and victory came an age of great economic growth. A grateful federal government enacted benevolent federal legislation that assisted returning veterans and the greater American population. With wartime advances and federally subsidized research came great technological innovation and medical/surgical advances. Public Health innovations and antibiotics changed the complexion of American disease from acute with high mortality to chronic with high morbidity. With companies offering excellent health care benefits to employees and their families and the federal government caring for a great many other through various programs (VHA system, Medicare, Medicaid), an individual was led to believe an entitlement existed. Others would pay for access to the best physicians in the best hospitals with the latest technology and therapeutics. But, the cost of doing medical business greatly increased. Research and education that fueled these great technological and therapeutic advances were costly. Economic downturns in the late Sixties and Seventies exposed medical financial turmoil. Medical specialization, reliance on the latest technology, and medically complex aging patients were driving the system toward collapse. Citizens, politicians, and businesses showed increased trepidation. Healthcare comprised greater than 10% of the GDP and continued to increase. The government paid for nearly two-thirds of all care. Citizens cared about quality and access. Politicians fretted over pleasing constituents. Business leaders worried about money. The current model required

revision. As with the generation prior, great medical changes lay ahead. But, this time cost, not war, was the catalyst.

Experts in the medical financial world attributed continually rising costs to three main factors:

1. Technological transformation of medical care; including new diagnostic techniques and new methods of medical treatment
2. The demand of consumers for low benefit care
3. The lack of budget limits on hospitals and the fee controls on physicians

B. What changes have been made as a consequence of cost?

1. Migration to a third party payer system

2. Development of DRG's for prospective payments

3. Creation of Hospital Systems, Mergers, Closures.

4. Increased cost to individuals in PPO

5. Performance improvement/Outcome measures.

6. Legislation enacted by federal and state governments

The two groups with the largest financial stakes; government and business have made changes, as a result of cost consequences. The government passed assorted legislation in the later part of the 20th century in the hopes of controlling costs. Collectively, government and business initiated the trend toward third party payers. The expectation being third parties would control costs. These components created as a response to cost will be addressed below.

The federal government experimented with cost containment measures in the 1970's. As these programs, targeted initially towards hospital, obtained success similar models were designed to curb the fees charged by physicians. Early programs included (1) establishment of reasonable cost limits on hospitals; (2) initiation of health care planning networks and requirement of "certificate of need" for hospital plant upgrades; (3) establishment of hospital review of care for federally funded patients to eliminate unnecessary costs; and (4) encouragement of HMO's to promote the use of preventive services and decrease the utilization of hospital inpatient care. These measures did not contain costs but lead to further change and set the stage for explosive growth of the third party payer model. Additional strategies in the early 1980's included procompetition. Aimed at giving tax deductions for those individuals and businesses purchasing group insurance policies. It achieved marginal success. In 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) was signed into law. It set limits on a per-case basis for hospital costs and placed limits on the annual rate of increase for Medicare's reasonable costs per discharge. The impact of this Act could never be determined because, one year later, the Prospective Payment System (PPS) was enacted. But TEFRA remained important legislation specifically because of section 223 limit that PPS borrowed. They included (1) grouping

hospitals by bed size and size of local; (2) wage adjustments by locality; and (3) an adjustment for case mix indexes. It became the basis for figuring reimbursement rates that paid hospitals by diagnosis-related systems (DRG) and was a major change from the pervious system. In PPS, the payment bears no relation to length of stay. If a hospital discharges a patient early, it can keep the gain. If a lengthy stay exceeds the reimbursement, the hospital absorbs the loss. PPS led to acquisition, mergers, and re-alignment in the medical industry in recent years. Another hospital change occurred in California in 1982, selective contracting. Selective contracting allowed Medical and private insurers to draw up contracts for the delivery of care and services to beneficiaries, selecting hospitals and later physicians that agreed to a negotiated price for their services. Selection went to the lowest cost bidder. Saving were large and analysis confirmed that in competitive managed care markets in California, selective contracting became the norm and hospitals showed slowed growth and lower relative costs since selective contracting was administered. These changes addressed the hospital-based element of cost in the medical industry. Focus, in the early 1990's, then turned to controlling the fees charged by physicians.

In January, 1992, Medicare initiated a system for physician reimbursement using a resource based relative value scale (RBRV). This set fee schedules for physicians treating Medicare patients. Non-government third party payers employed this model on physicians prior to the legislation. The emergence of third party occurred long before 1992.

Third party payer organizations and model are known as managed care. There are four major components to managed care: purchaser/payer, health insurance, providers of care, and patients/public. The two representatives offered are preferred provider organizations (PPO) and health maintenance organizations (HMO). There is a third that is a combination of (PPO) and (HMO) named point of service (POS). Organizations responsible for the health care of large groups of people typically hire a third party to administer the healthcare program. The expectation is that cost will be fixed for periods of time. This allows for these large organizations to plan health care expenditures into an operating budget.

PPO's are designed to allow the patient to choice from a list of providers but requires a payment for that choice. HMO's assign patients to a provider and no choice is allowed. A POS differs in that it charges higher copay but the patient may go to a physician of choice. Managed Care organizations then create contracts with groups of physicians, health care networks, or physician employees of the managed care organization. Managed care organization desire to remain solvent. There fore the funds provided by the payee must not exceed the costs charged by the providers. Because of this there are key principle regarding the managed care operations.

1. The need for education and preparation of the insured
2. Importance of information systems and insistence on quality and outcomes measures
3. Plan/provider control utilization
4. Capitation
5. Risk Sharing
6. Importance of contracts

C. How have the changes addressed the issue of cost?

The changes reflected in section B. as a response to cost certainly changed the way the medical industry runs. Where once existed a model of provider service supply and patient preference demand has been replaced by the dominant influence of third party payers and complex legislation. Third parties dictate where patients receive care and direct physician and hospitals on providing care and billing amounts. This created a paradigm shift, indeed.

Hospital's reaction paralleled physician reaction regarding the new reimbursement paradigm. Both models consolidated, vertically integrated, shared resources, joined insurance plans, created specialty markets, and hired business mangers for assistance. The key difference has been the shift from inpatient to outpatient treatment. But these reactions to attempts to control costs, not cost outcomes.

This question is difficult to determine. Selective contracting in California produced savings and has been adopted by the major third party payers. DRG's serve as a payment basis in at least nine other industrialized countries second to its success in the US. Success has been made but, all would agree the health care system in this country remains in fiscal disarray. Managed care has not decreased costs or even held cost below the rate of inflation. Has managed care performed better than its predecessor? We do not know. Is managed care the solution? As a group, we feel it maybe to early to tell. By in large, one thread remains relatively consistent since WWII. The typical individual still pays a fraction or zero of the cost of their personal health care. Considering the magnitude of the cost and all the changes made to control these costs, the direct beneficiary of these services still contributes next to nothing.

Within health care the spectrum consists of individuals paying full costs or third party payers covering the entire cost. In the initial method all accountability is placed on the individual and healthcare becomes commodity. The second method fosters no personal accountability and makes healthcare an entitlement. Managed care appears to be a compromise that strongly favors the recipient. As it evolves, one hopes that the system will achieve cost savings. This will be a tall order for a country that will not tolerate health care rationing. Less palatable are the alternatives: individual and third party payer share a reasonable burden of the cost or socialized medicine. Individuals oppose increased personal expense. Socailized medicine remains a highly politicized issue and would lead to medical rationing to control costs. We wait as the future unfolds before us.